U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 May 2006

CASE NO.: 2005-BLA-5686
2005-BLA-46

In the Matter of

MARY LOU OHLER, o/b/o
HARVEY N. OHLER (Deceased)
and Widow of
HARVEY N.OHLER
Claimant

v.

ISLAND CREEK COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Robert J. Bilonick, Esq.,
For the Claimant

William S. Mattingly, Esq.,
For the Employer

Susan M. Jordan, Esq.,
For the Director

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING LIVING MINER'S AND SURVIVOR'S BENEFITS

This proceeding arises from a consolidated living miner's subsequent claim for benefits and survivor's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as

amended ("Act"). The living miner's claim was filed on March 10, 1999; the survivor's claim was filed on February 27, 2004.[1] The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 ("Regulations"), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The above-captioned claim is a consolidated duplicate living miner's claim ("LM") and a survivor's claim ("WM") for benefits.

The living miner's claim is the miner's third claim for benefits. He filed his first prior claim on September 10, 1984. (LM Director's Exhibit ("DX") 38-1). The claim was denied by the District Director on February 7, 1985 because the evidence failed to establish that the miner's CWP was caused at least in part by coal mine employment or that he was totally disabled due to pneumoconiosis. (LM DX 38-14). No further proceeding occurred in connection with the miner's first claim. The miner filed his second claim for benefits on January 1, 1991. It was denied on May 31, 1991 because the miner did not establish any of the elements of entitlement or a material change in condition. (LM DX 39-19).

The miner filed his current claim on March 10, 1999. (LM DX 1). The living miner's claim was approved by the District Director on September 3, 1999 because the evidence established the elements of entitlement, effective December, 1999. (LM DX 36). Thereafter, the Employer requested a hearing before an administrative law judge. (LM DX 34-35). After an October 18, 2000 hearing in Pittsburgh, Pennsylvania, I issue a Decision & Order Awarding Benefits, dated September 5, 2001. (LM DX 79). Thereafter, the Employer appealed that Decision to the Benefits Review Board. (LM DX 80). On September 30, 2002, the Board vacated the Decision and remanded the case for further consideration. (LM DX 90).[2]

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[1] Because it was filed after January 19, 2001, the Regulations, as amended in 2001, shall apply *in toto* to the survivor's claim. Pursuant to 20 C.F.R. § 725.2(c)(2001), because the living miner's claim was filed before January 19, 2001, the amended Regulations shall also apply to it, with the exception of the following sections: §§ 725.101(a)(31), 725.204, 725.212(b), 725.213(c), 725.214(d), 725.219(d), 725.309, 725.310, 725.351, 725.360, 725.367, 725.406, 725.407, 725.408, 725.409, 725.410, 725.411, 725.412, 725.414, 725.415, 725.416, 725.417, 725.418, 725.421(b), 725.423, 725.454, 725.456, 725.457, 725.458, 725.459, 725.465, 725.491, 725.492, 725.493, 725.494, 725.495, 725.547, and 725.701(e). Those sections as set forth in the pre-Amendment version of the Regulations shall apply to the living miner's claim.

[2] Specifically, the Board vacated my findings pursuant to 20 C.F.R. § 725.202(a) and directed this Court to reevaluate the evidence consistent with *Milburn Colliery Co. v. Hicks*, 138 F.3d 524 (4th Cir. 1998), *Underwood v.*

The miner died on August 23, 2002. By Order dated February 3, 2003, I granted the Claimant's request to remand the case to the District Director for consideration of the autopsy report and death certificate and for consolidation with a potential survivor's claim. (LM DX 94). On June 30, 2003, after considering the additional evidence, the District Director again approved the living miner's claim. (LM DX 102). On July 9, 2003, the Employer again requested a hearing on the matter before an Administrative Law Judge. (LM DX 103). After the living miner's claim was singularly referred to this Court, Administrative Law Judge Gerald M. Tierney issued an Order, dated April 23, 2004, again remanding the claim to the District Director for consolidation with the survivor's claim. (LM DX 116).[3] On May 5, 2004, the District Director formally consolidated the living miner's claim with the now-filed survivor's claim. (LM DX 117).

The miner's widow filed her survivor's claim for benefits on February 27, 2004. (WM DX 3). That claim was denied by the District Director on December 3, 2004 because the evidence failed to show that pneumoconiosis caused the miner's death. (WM DX 23). On December 14, 2004, the Survivor requested a hearing before an administrative law judge. (WM DX 25).

Both claims were referred to the Office of Administrative Law Judges on March 15, 2005. (LM DX 118; WM DX 27). On December 2, 2005, I conducted a conference call with representatives of the parties, a transcript of which is made a part of the record. (Conference Transcript ("CT")). The primary focus of that conference call was the evidentiary record in the survivor's claim.

I then conducted a hearing on December 6, 2005 in Pittsburgh, Pennsylvania, which was limited to matters dealing with the living miner's claim.[4] (Hearing Transcript ("HT") 6). The Claimant and Employer were represented by counsel. Although a written appearance had previously been entered for the Director, Office of Workers' Compensation Programs ("OWCP"), the Director was not represented at the hearing. The parties were afforded the full opportunity to present evidence and argument. Because the living miner's claim was filed prior to January 19, 2001 the evidence limitation found in 20 C.F.R. § 725.414(2001) do not apply to it. Claimant's exhibits ("CX") A-P[5] Director's exhibits ("DX") 1-120, and Employer's exhibits ("EX") 1-16 were admitted into the record.[6] The Employer subsequently withdrew LM EX 16.

Elkay Mining Inc., 105 F.3d 951 (4th Cir. 1997), and *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438 (4th Cir. 1997).

[3] Judge Tierney conducted a brief hearing on February 23, 2004 in Morgantown, West Virginia. At the hearing, there was some confusion between respective counsel and the Court as to whether the matter at hand was a living miner's claim or a survivor's claim. Subsequent correspondence from counsel to the Court revealed that the matter was indeed a living miner's claim. Therefore, Judge Tierney's Order pertained to the living miner's claim.

[4] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(*en banc*), the location of a miner's last coal mine employment is determinative of the circuit court's jurisdiction. Here, the miner's last coal miner employment was in West Virginia. (LM DX 63 at 74). Therefore, Fourth Circuit law applies to this case.

[5] LM CX P was identified at the hearing as the deposition of Dr. Ashcraft. Although Claimant subsequently labeled a different document as LM CX P in transmission of evidence to this Court, that exhibit designation shall continue to pertain to the deposition of Dr. Ashcraft.

[6] Hereinafter, exhibits will also be identified by whether they were admitted in the living miner's claim ("LM") or the survivor's claim ("WM").

By correspondence to this Court received March 31, 2006, counsel for the Claimant stated that both parties agree that no additional hearing is necessary for matters dealing with the survivor's claim. Because it was filed after January 19, 2001, the evidence limitations found in 20 C.F.R. § 725.414(2001) apply to the survivor's claim.[7] The parties also jointly requested that all of the evidence developed in the living miner's claim should be admitted in the survivor's claim for good cause. By Order dated April 4, 2006, I denied this request and directed the parties to designate the evidence they move to admit in the survivor's claim.

The Survivor has proffered WM CX 1-9.[8] Of these exhibits, I admit WM CX 1-6 and WM CX 9. The exhibits proffered as WM CX 7 and 8, the deposition transcripts of Dr. Harold G. Ashcraft and Dr. Joshua A Perper, respectively, are disallowed for purposes of the survivor's claim. Admissible deposition transcripts are limited to physicians who submitted medical reports; alternatively, they may be submitted in lieu of medical reports if doing so would not exceed the evidentiary limitations. 20 C.F.R. § 725.457(c)(2)[9] Drs. Ashcraft and Perper each prepared reports designated as autopsy reports for the purposes of the survivor's claim.[10]

The Employer has proffered WM EX 1-10. Of these, I admit WM EX 1-4 and 8-10.[11] The exhibits proffered as WM EX 5-7, the deposition transcripts of Drs. Joseph F. Tomashefski, Everett Oesterling, and Perper, respectively, are disallowed as evidence in the survivor's claim as they too represent the deposition of doctors who prepared reports designated as autopsy reports.[12]

I admit WM DX 1-29. The exhibits proffered as WM DX 9-11 each represent hospital records that the District Director obtained from hospitals pursuant to 20 C.F.R. § 725.405. However, pursuant to 20 C.F.R. § 725.421(b)(4), only certain medical evidence is to be transmitted from the District Director to the Office of Administrative Law Judges when a formal hearing is requested. This list includes all of the evidence proffered by the parties and the medical examination conducted pursuant to § 725.406. This limited list does not include hospital

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[7] *See Church v. Kentland-Elkhorn Coal Corp.*, BRB No. 04-0617 BLA (April 8, 2005) (unpub.) (Holding that in living miner's and subsequently filed survivor's claims, the evidence from the living miner's claim is not automatically admitted in the survivor's claim. Rather such evidence must be designated by a party, and is subject to the evidentiary limitations of § 725.414, to be included in the survivor's claim).

[8] The Survivor submitted WM CX 1-7 in correspondence to this Court dated April 13, 2006 and WM CX 8-9 in correspondence to this Court dated April 20, 2006.

[9] That provision states that any physician offering testimony "must have prepared a medical report." *See also* 20 C.F.R. § 725.414(c), which limits parties to the testimony of no more than two physicians, but is silent as to the total number of depositions of those two physicians that may be submitted.

[10] It should be noted that the depositions transcripts of Drs. Ashcraft and Perper are admitted in the living miner's claim because that claim is governed by the pre-Amended Regulations, which do not limit testimony to those who provide medical reports. Additionally, with respect to Dr. Perper, even if such a requirement were applicable to the living miner's claim, his testimony would still be admissible because his report is a medical report, for the purposes of the living miner's claim, because it goes beyond a review of slides.

[11] The exhibit identified as WM EX 10 is a significantly redacted version of LM DX 55. Because it has been altered so drastically for the purpose of the survivor's claim, I will refer to it by a separate exhibit number. I note that the Employer has included the results of several objective medical tests in WM EX 10. This evidence is already on the record in the living miner's claim and is identical in form. The degree to which it is considered in the survivor's claim is discussed *infra*.

[12] Again, because the living miner's claim is governed by the pre-Amendment Regulations, the deposition testimony of these three doctors is admitted for the purposes of the living miner's claim.

records obtained by the District Director pursuant to § 725.405. Therefore, absent the proffering of these exhibits by a party, they would not be admitted. By correspondence to this Court received April 13, 2006, Claimant has proffered these exhibits and, accordingly, they are admitted.

Additionally, the Claimant has adopted the autopsy report of Dr. Ashcraft for purposes of rebuttal in the survivor's claim.

ISSUES

I. Whether the decedent-miner had pneumoconiosis as defined by the Act and the regulations?

II. Whether the decedent-miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the decedent-miner was totally disabled?

IV. Whether the decedent-miner's disability was due to pneumoconiosis?

V. Whether there had been a material change in the decedent-miner's condition since the most recent prior denial of his claim?

VI. Whether the decedent-miner's death was caused by pneumoconiosis?

FINDINGS OF FACT

A. Survivorship[13]

I find that Mrs. Ohler is an eligible survivor of the miner. (HT 14-15).

B. Coal Miner

[13] 20 C.F.R. § 725.212 puts forth the following as conditions of entitlement for a surviving spouse:

(a) An individual who is the surviving spouse or surviving divorced spouse of a miner is eligible for benefits if such individual:

(1) Is not married;

(2) Was dependent on the miner at the pertinent time; and

(3) The deceased miner either:

(i) Was receiving benefits under section 415 or part C of title IV of the Act at the time of death as a result of a claim filed prior to January 1, 1982; or

(ii) Is determined as a result of a claim filed prior to January 1, 1982, to have been totally disabled due to pneumoconiosis at the time of death or to have died due to pneumoconiosis. A surviving spouse or surviving divorced spouse of a miner whose claim is filed on or after January 1, 1982, must establish that the deceased miner's death was due to pneumoconiosis in order to establish entitlement to benefits, except where entitlement is established under § 718.306 of part 718 on a claim filed prior to June 30, 1982.

(b) If more than one spouse meets the conditions of entitlement prescribed in paragraph (a), then each spouse will be considered a beneficiary for purposes of section 412(a)(2) of the Act without regard to the existence of any other entitled spouse or spouses.

The Claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations. The parties stipulated and I find that the miner had 36 years of coal mine employment. (HT 9).

C. Date of Filing

The miner filed his claim for benefits on March 10, 1999. The survivor filed her claim for benefits on February 27, 2004. None of the Act's filing time limitations are applicable for either claim; thus, both claims were timely filed.

D. Responsible Operator

The parties have stipulated and I find that Island Creek Coal Co. is properly designated as the responsible operator in this case. (HT 8).

E. Dependents

The miner had one dependent for the purposes of augmentation, his surviving wife Mary Lou Ohler.

F. Personal Information

The miner was born on July 16, 1927. He married Mary Lou Emerick on August 31, 1951. He last worked in the mines with Island Creek in January, 1990. His last position was that of a motorman. (LM DX 63 at 50). All of his coal mine employment was underground. (LM DX 63 at 55). During his career, the miner engaged in heavy lifting, loading, hauling, and crawling. (LM DX 63). At the 2000 hearing, the miner testified that he could no longer perform his last coal mine work due to shortness of breath. (LM DX 63 at 76).

The miner also testified that he smoked a half-pack to a pack of cigarettes per day for no more than one year. (LM DX 63 at 62-63).

The miner died on August 23, 2002. (LM DX 95).

II. Medical Evidence

A. Chest X-rays

The record contains thirty admitted readings of five chest X-rays that were taken from October 15, 1984-November 4, 1999. Of the thirty readings, sixteen were interpreted as negative and fourteen were interpreted as positive for the presence of pneumoconiosis as defined by the Regulations. All thirty readings will be considered in the living miner's claim. The parties have designated which readings should be considered in the survivor's claims in accordance with the 2001 evidence limitations. A summary of the X-ray evidence, including the designations for the survivor's claim, is found in Appendix A.

B. Pulmonary Function Studies[14]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Tra-Cings**	**Com-prehen-sion Cooper-ation**	**Qualify * Conf-orm****	**Dr.'s Impression**
Bloom 10/15/84 LM DX 38-6	57 69"	2.69	105.36	3.71		Good Good	No*	Suggests early obstructive pulmonary impairment. Fino finds normal ruling out obstruction, restriction, or ventilatory impairment. (DX 29). Dr. Morgan finds normal. (DX 32; EX 9, p. 75). Dr. Spagnolo suggests mild airflow obstruction, but no restriction. (EX 5).
St. Frances 04/17/90 LM DX 25, 39	62 68"	2.49	93	3.41	Yes		No*	Dr. Morgan finds test valid. (DX 32). Dr. Spagnolo finds no evidence of chronic fixed obstruction or restriction. (EX 5).
Parcinski 02/06/91 LM DX 39-11	62 68"	2.42 2.36+	116.36 130.03 +	3.24 3.20+	Yes	Good Good	No* No*	Mild obstructive impairment. Fino finds PFS invalid due to premature termination of exhalation & lack of reproducibility on tracings. Fino finds no ventilatory impairment. (DX 29). Dr. Lantus finds PFS technically acceptable. (DX 39-15). Dr. Spagnolo finds no

[14] § 718.103 (a)(Effective for tests conducted after Jan. 19, 2001(see 718.101(b))), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function tests are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Tra-Cings	Com-prehen-sion Cooper-ation	Qualify * Conf-orm**	Dr.'s Impression
								obstructive impairment but can not determine if a restriction exists. (EX 5).
St. Frances 03/25/93 LM DX 25	65 68"	2.26	92	3.25	Yes		No*	Dr. Spagnolo finds no evidence of chronic obstruction or restriction. (EX 5).
Malhotra 04/12/99 LM DX 11	71 66.5"	2.23	88	3.35	Yes	Good Good	No*	No post-bronchodilator because of dyspnea. Dr. Spagnolo finds no evidence of chronic fixed obstruction or restriction but there may be very mild airflow obstruction. (EX 5). Dr. Morgan finds a gradually worsening lung function with a mild restrictive impairment. (EX 9, p. 81).
Schaaf 07/01/99 LM DX 13	72 67"	2.08 2.12+	83 77+	3.32 3.37+	Yes	Good	No* No*	Schaaf finds abnormal with mild obstructive LD. Mild airflow obstruction but normal vital capacity. (DX 13). He finds PFS valid. (CX 12, p. 22). Dr. Morgan agrees there may be mild obstruction. (DX 32; EX 9, p. 82). Dr. Spagnolo finds no evidence of restriction, but there may be very mild airflow obstruction. (EX 5).
Fino 11/04/99 LM DX 26	72 67"	1.96 1.99+	75 80+	3.14 3.32+		Good	No* No*	Malhotra finds abnormal FEV-1 & FVC. (Dep. 45-6). Dr. Spagnolo finds no evidence of restriction, but there may be very mild airflow obstruction. (EX 5).

* A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).
+Post-bronchodilator.
Appendix B (Effective Jan. 19, 2001 for tests on or after that date) states: "(2) The administration of pulmonary function tests shall conform to the following criteria:
(i) Tests shall not be performed during or soon after an acute respiratory illness. . ."

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve this degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of sixty-seven inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.63 for a male 72 years of age.[15] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.12 or an MVV equal to or less than 65; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	age	FEV_1	FVC	MVV
69"	57	2.01		
68"	62	1.87		
68"	65	1.82		
66.5"	71	1.60		
67"	72	1.63	2.12	65

All seven PFS tests shall be considered in the living miner's claim. For the survivor's claim, the Claimant has designated LM DX 38-6 and LM DX 13 as its affirmative evidence and has designated LM DX 27 as rebuttal to LM DX 26, which is proffered by the Employer. The Employer has designated LM DX 26 and LM DX 39 as its affirmative evidence in the survivor's claim.

[15] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the test are "qualifying." *Toler v. Eastern Associated Coal Co.*, 43 F.3d 3 (4th Cir. 1995). I find the miner is 67.5" here, his average reported height.

C. Arterial Blood Gas Studies[16]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled. The blood gas study evidence is summarized below.

Date Ex.#	Physician	PCO_2	PO_2	Qualify	Physician Impression
10/15/84 LM DX 38-8	Bloom	39 41+	62 66+	No No+	Fino finds mild hypoxia. (DX 29; EX 10, p. 75). Dr. Morgan finds mild hypoxia. (DX 32; EX 9, p. 75-6). Schaaf finds significant hypoxemia. (CX 12, p. 35).
02/06/91 LM DX 39-14	Parcinski	38 32+	60 64+	Yes Yes+	Dr. Morgan finds suggestion of moderate hypoxia. (DX 32). Morgan says obesity affects test. Dr. Lantos finds test acceptable. (DX 32). Fino agrees it's mild hypoxemia which, at rest, is not debilitating. (EX 10, p. 72).
05/26/99 LM DX 11, 14	Pickerill BCI(P))	36 39+	66 40+	No Yes+	Dr. Malhotra finds resting hypoxemia on exercise. Mild reduction in PO_2 resting & severe reduction on exercise. Dr. Ranavaya finds test acceptable. (DX 14). Malhotra finds valid. (Dep. 30). Dr. Spagnolo questions validity. (EX 5). Morgan finds exercise response consistent with fibrosing alveolitis. (EX 9, p. 79). Dr. Fino may have found this invalid. (EX 10, p. 69).
11/04/99 LM DX 26	Fino (BCI(P))	39	55	Yes	Abnormal. Moderately severe hypoxia. Malhotra finds significantly bad results. (Dep. 45-6). Dr. Morgan finds worsening progression characteristic of fibrosing alveolitis.

[16] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies. 20 C.F.R. § 718.204(b)(2) permits the use of such studies to establish "total disability." It provides:

> In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability: . ..
>
> (2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part . . .

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

All four blood gas studies shall be considered in the living miner's claim. For the survivor's clam, the Claimant has designated LM DX 39-8 and LM DX 11 as its affirmative evidence. The Claimant has also designated LM DX 27 as evidence rebutting LM DX 26, which is proffered by the Employer.[17] The Employer designates only LMDX 26 as its affirmative blood-gas study evidence in the survivor's claim

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

All physicians' reports are admitted in the living miner's claim. For the survivor's claim, the Claimant has designated WM CX 1 and WM CX 2 as its allotted medical report evidence. The Employer has designated LM DX 22 and LM EX 5[18] and LM EX 8.

The parties have also intricately designated autopsy report evidence, an issue that merits discussion. In an unpublished decision, the Board adopted the Director's position that only the original prosector's report shall be considered as a "report of autopsy" for the purposed of the evidentiary limitations at 20 C.F.R. § 725.414. *Kalist v. Buckeye Coal Co.*, BRB No. 03-0743 BLA (July 23, 2004)(unpub.). By correspondence received December 15, 2005, the Director informed this Court that it has reconsidered its position since the *Kalist* decision. The Director now states that a slide review by a pathologist who was not present at the autopsy constitutes an autopsy report for the purposes of 20 C.F.R. § 725.414(a)(2)(i) & (a)(3)(i). The Director reasoned that if such reviews did not constitute autopsy reports, "there would be no point to including autopsy reports in the evidentiary limitations because there would virtually always be only one."

The Director has further put forth that in cases where a report includes both a slide review and a consideration of additional evidence, the document shall be considered both an autopsy report and a medical report for the purposes of the evidentiary limitations. Such a document may

[17] The Claimant also designated LM DX 14 as evidence rehabilitative of LM DX 11. However, this evidence is not admitted for purposes of rehabilitation as 20 C.F.R. § 725.414(a)(2)(ii) only allows rehabilitation evidence, after rebuttal by the other side, in the form of a statement from the physician who administered the original test. Here, Claimant proffers a statement by Dr. Ranavaya to rehabilitate a test conducted by Dr. Pickerill. Therefore, it does not conform to the requirements for rehabilitative evidence under the Regulations.

[18] These two documents, the reports of Dr. Spagnolo, shall be considered jointly as one single exhibit.

be considered only as an autopsy report if references to the additional medical evidence are redacted.

The Director's current reasoning is consistent with the facts of this case. Indeed, the Employer was not made aware of the miner's death prior to the autopsy and subsequent burial. (CT 6). Therefore, to procure an autopsy per the Director's position in *Kalist* would require an exhumation. However, by correspondence received December 13, 2005, Claimant informed this Court that an exhumation would not yield autopsy results in this case because the organs were not interred with the body but rather incinerated after the autopsy. Moreover, the exhumation process, if it were a viable option, would cost in excess of $3,500.00. Additionally, the miner's family believes this option to be morally reprehensible. Moreover, an autopsy post-exhumation at this late date would be useless. By correspondence received December 16, 2005, the Employer concurred with the facts presented by the Claimant on this issue.

Therefore, I agree with the Director's position, as expressed in its correspondence to this Court, shall govern the issue of admissible autopsy evidence. Additionally, to comply with 20 C.F.R. § 718.106, a slide review proffered as an autopsy report shall also reflect consideration of the prosector's gross description. In the event that strict adherence to the Director's position in *Kalist* is required, I find, for the factual reasons stated above, good cause to admit reviews of autopsy slides by pathologists in the survivor's claim. In the event that the good cause route is appropriate, the evidence designations of the parties shall govern how the evidence is admitted.

Accordingly, WM CX 3 is admitted as the Claimant's initial autopsy report, DX 9 is admitted as rebuttal of WM EX 3, and WM CX 4 is admitted in rehabilitation. For the Employer, WM EX 3 is admitted as initial evidence and WM EX 6 is admitted as rebuttal of WM CX 3.[19]

Dr. Marvin Bloom, whose credentials are unknown, examined the miner on October 15, 1984. (LM DX 38-6). He noted a one year pack per day smoking history ending in 1958 and about 38 years of coal mine employment. Based upon history, examination, negative ("0/1") X-ray, non-qualifying PFS, and a non-qualifying AGS, he concluded it was a normal cardio-pulmonary examination.

Dr. Richard Parcinski, whose qualifications are unknown, examined the miner on February 6, 1991 and submitted a report. (LM DX 39-13). Mr. Ohler complained of dyspnea difficulty walking up hills. He noted a non-smoking history and a 20 year coal mine employment history. He observed diffuse bilateral fibrotic crackles on examination. Based on a negative X-ray, non-qualifying PFS showing a mild obstructive defect, qualifying AGS showing mild hypoxemia, examination, normal EKG, and history, Dr. Parcinski idiopathic interstitial

[19] Because WM CX 3, WM CX 4, WM EX 3, and WM EX 6 include considerations of additional medical evidence, such references are redacted and only reference to the review of autopsy slides is admitted for the purpose of the survivor's claim. These reports are considered medical reports and admitted *in toto* for the purpose of the living miner's claim.

pulmonary fibrosis ("IPF") of unknown etiology.[20] He found only a mild impairment from the IPF.

Dr. Vijay K. Malhotra is board-certified in internal medicine. His report, based upon his examination of the claimant, on April 12, 1999, notes at least 31 years of coal mine employment and a non-smoking history. (LM DX 12). Dr. Malhotra noted the miner's complaint that he could only walk four blocks on level ground, climb thirteen steps or go 200 feet uphill without being impacted by his affliction. He recommended referral for hypoxemia.

Based on examination, history, arterial blood gases, a non-qualifying pulmonary function study showing severe small airway disease, and a positive ("2/1") chest X-ray, Dr. Malhotra diagnosed CWP due to coal dust exposure and found the miner totally disabled from the same. (DX 12) Dr. Malhotra was deposed on December 9, 1999. (LM DX 27). He has extensive experience treating coal miners. Dr. Malhotra reiterated the substance of his earlier report. He testified he had reviewed additional reports, i.e., those of Drs. Fino and Schaaf. (LM DX 27 at 44). He explained CWP starts as a small airways disease and in most cases progresses on to large airways disease initially causing obstructive impairment then later restrictive impairment. Once the coal dust particle becomes embedded in lung tissue, the process continues despite cessation of exposure. (DX 27 p. 10). It affects blood gas transfer because the scarred lung tissue impairs the transfer of O2 from the alveoli to the blood vessels. CWP is not a "reversible" disease so, in most cases, bronchodilators really do not improve it. (LM DX 27 at 20). He explained the various types of emphysema. (LM DX 27 at 64).

According to Dr. Malhotra, Mr. Ohler's expiratory rhonchi were consistent with obstructive lung disease and CWP. (LM DX 27 at 21). He expressed concern over the shape and size of the opacities shown by X-ray noting CWP normally yields rounded opacities and normally begins in the upper lung zones. Yet, Mr. Ohler had fibrotic lung changes which could not be otherwise explained and one with CWP may have irregular-shaped opacities. (LM DX 27 at 25-29, 59). Moreover, subsequent X-rays, read by Drs. Mital and Barrett, showed involvement of additional lung zones. (LM DX 27 at 54). He noted Mr. Ohler's lung disease could be asbestosis, silicosis, or anthracosis because of his coal mine exposures, but the only way to diagnose those afflictions is via autopsy. (LM DX 27 at 29). It is not likely asbestosis. (LM DX 27 at 60). Mr. Ohler's inhalation of sand, anthracite and silica, on the job, might account for him showing more linear than rounded opacities. (LM DX 27 at 61). He discussed Mr. Ohler's PFS. (LM DX 27 at 29-37). His MVV shows severe small airways disease and moderate obstructive disease. (LM DX 27 at 36). Dr. Malhotra discussed Mr. Ohler's "significantly abnormal" AGS showing moderate hypoxemia. (LM DX 27 at 38-43). Mr. Ohler has no cardiac problem. (LM DX 27 at 43-44).

Dr. Fino's tests were consistent with pulmonary fibrosis, according to Dr. Malhotra. (LM DX 27 at 46). He disagreed with the former's conclusion it was "idiopathic." because it's clear cause was 39 years of coal mine employment dust exposure ruling out other potential

[20] "Hypoxemia" is defined as "deficient oxygenation of the blood; hypoxia." "Hypoxia" is defined as a "reduction of oxygen supply to tissue below physiological levels despite adequate perfusion of the tissue by blood." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 28TH ED. (1994) at 812.

causes. (LM DX 27 at46-47). Moreover, he does not believe Mr. Ohler suffers from IPF because it is an insidious disease which begins slowly at a much younger age. (LM DX 27 at 49). Mr. Ohler lacks the symptoms of IPF, i.e., cyanosis and huge clubbing. He believes Dr. Fino diagnosed IPF because of his "0/0" reading of an X-ray. (LM DX 27 at 59). Dr. Malhotra admitted, on cross-examination, it would be unusual to some degree for one to suffer from this degree of abnormality with a category "2" X-ray. (LM DX 27 at 52). His obstructive and restrictive lung diseases are consistent with a coal dust disease, i.e., CWP. (LM DX 27 at 58).

Dr. W. K. C. Morgan, a member of a number of societies, is a B-reader and very well published in the field of pulmonary diseases, including CWP and other occupational lung diseases.[21] (LM DX 32). He received his medical education in the United Kingdom in the early 1950's and has worked with those afflicted with occupational lung diseases. He testified his credentials are the equivalent of board-certification. Dr. Morgan has extensive experience dealing with coal miners. His consultation report, dated February 16, 2000, based upon review of enumerated medical information of the claimant, notes 38.5 years of coal mine employment and a five-year pack per day smoking history reported to Dr. Bloom. He observes Mr. Ohler told Drs. Malhotra and Schaaf he had never smoked.

Dr. Morgan disagreed with Dr. Malhotra's statement that CWP starts in the small airways and progresses to the large airway. (WM DX 32 at 84-85). He says the large airways are involved only by bronchitis. Nor was Dr. Malhotra correct concerning CWP progression- "It certainly does not progress after exposure has ceased with the exception of some subjects who have PMF." Dr. Morgan, unlike Dr. Malhotra believes the miner was overweight. He notes Dr. Malhotra found expiratory rhonchi, which are not explained by CWP and generally are found in asthma and bronchitis. Others found crackles which are virtually always heard on inspiration. He believes Dr. Malhotra was "poorly informed concerning the type of opacities seen in CWP. He wrote idiopathic pulmonary fibrosis is an affliction which is as common in housewives and bank teller as coal miners. There is no causal relationship between coal mine dust inhalation and interstitial pulmonary fibrosis. He suggests Dr. Malhotra did not know the difference between focal and centriacinar emphysema. Dr. Spagnolo agrees with Dr. Morgan's assessment of Dr. Malhotra's opinion. (LM DX 50).

Dr. Morgan finds the miner undoubtedly has developed idiopathic pulmonary fibrosis or "fibrosing alveolitis," commonly found in those over 50. Studies suggesting it is more frequent in coal miners are flawed. He opines that Mr. Ohler's condition clearly developed between 1996 and 1997 and is progressing. Since he had no evidence of CWP when he stopped mining, "any deterioration in his lung function cannot have occurred as a result of his exposure to coal dust." The mild obstruction in 1999 could be related to his prior smoking. He has a moderate impairment due to fibrosing alveolitis, a form of pulmonary fibrosis. He is totally impaired partly because of his age, "but mainly because of his interstitial fibrosis unrelated to CWP or his occupation. (LM DX 32).

[21] The claimant accepted Dr. Morgan as an expert witness and I find he was so qualified. (LM DX 63 at 36).

Dr. Morgan testified at a deposition, on October 6, 2000 and on November 16, 2000. (LM DX 53; LM DX 54). He reiterated his credentials and the substance of his earlier report. He responded, at length concerning the article he co-authored, "Airway Obstruction, Coal Mining and Disability" and added the paper reflects his current opinions recognizing that some circumstances have changed since 1994. (LM DX 53 at 12-18; LM DX 54 at 93-96). He regards simple CWP as "a disease induced by the inhalation of coal dust and the tissue's reaction to its presence." He observed the legal definition includes silicosis which may or may not worsen post-coal mining with further silica exposure and industrial bronchitis which generally improves after exposure ceases. (LM DX 53 at 21, 25). CWP is not a form of interstitial fibrotic disease of the lung, but a nodular fibrosis of the lung. (LM DX 54 at 131).

Dr. Morgan believes simple CWP does not progress post-exposure, but a category "2/3", and uncommonly category "1", can become complicated CWP or PMF. (LM DX 53 at 22-23, 27-28, 50, 138, 155). Later, he testified CWP is a progressive disease if one's exposure continues, except for those, category "2" or "3", who develop PMF without continued exposure. (LM DX 54 at 86, 138, 155). Dr. Morgan testified that simple medical CWP only progresses radiographically if the miner continues exposure to coal dust. (LM DX 54 at 136). He explained simple CWP and simple silicosis differ, in that he has seen miners afflicted with silicosis worsen for three to four years after exposure ceased then stabilize. (LM DX 54 at 86, 155).

According to Dr. Morgan, no one knows what causes simple CWP to progress into complicated CWP. (LM DX 53 at 25). If complicated CWP, an uncommon disease, appears, it is usually within five years of cessation and usually in younger miners. (LM DX 53 at 27). It took over ten pages of deposition testimony for Dr. Morgan to respond to questioning finally expressing his belief that although it is uncommon, one with category "1" X-ray evidence of CWP can, but rarely does, have disabling pulmonary dysfunction. (LM DX 53 at 27-39, 50). X-ray category "2/3" will cause a reduction in PO2 in some persons, but it is exceedingly uncommon in non-smoking radiographic category "1" cases. (LM DX 53 at 39-40). In non-smokers, it is exceedingly uncommon for radiographic category "1" CWP for a reduction in PAO2 levels. (LM DX 53 at 40). In categories "2/3" there is some mild arteriole hypoxemia. (LM DX 53 at 41). He explained how CWP affects gas exchange. (LM DX 54 at 97-98) Aside from category "1" and "2" CWP which show little effect, there is a correlation between the worsening of CWP and falling PO2 levels. (LM DX 54 at 98). Ordinarily, those with category "0" or "1" CWP have normal AGS. (LM DX 54 at 99). He is aware of literature showing category "0" or "1" CWP have uncommonly shown blood gas abnormalities on exercise. (LM DX 54 at 100). Dr. Morgan opined obesity is manifested by a restrictive lung impairment. (LM DX 54 at 101). The worse the obesity the worse the restriction. (LM DX 54 at 102). Dr. Morgan was unaware of literature which suggests CWP can be associated with increased pulmonary hypertension. (LM DX 54 at 152). He generally agreed with the standards referenced in exhibit 3 to EX 9, pathology standards. (LM DX 54 at 153).

Dr. Morgan admitted, on reflection, that his "obesity" explanation for the abnormal 1991 AGS, may not have been entirely accurate since it was in fact the miner's early fibrosing alveolitis which was responsible for the abnormality. (LM DX 54 at 126-130, 149). The miner's weight now has negligible impact. (LM DX 54 at 150).

Dr. Morgan testified that the changes he observed on the miner's X-rays were consistent with fibrosing alveolitis or idiopathic pulmonary fibrosis, which generally occurs in the elderly and is unrelated to coal mining. (LM DX 54 at 66, 73). The disease is characterized by irregular opacities in the lower zones which gradually work upwards and by crackles. (LM DX 54). He believes there is no question the miner has a totally disabling pulmonary impairment, i.e., fibrosing alveolitis, which nobody knows the cause of. (LM DX 54 at 87-89). Although it is difficult to say, the miner's disability probably began around 1991 to 1992. (LM DX 54 at 151). He opined it was not caused by his coal dust exposure because it occurs in the general population. (LM DX 54 at 89). The miner does not have sarcoidosis. (LM DX 54 at 143).

Dr. John T. Schaaf, is board-certified in critical care medicine and internal medicine with a sub-specialty in pulmonary medicine.[22] His initial report, based upon his examination of the miner, on July 1, 1999, notes 38.5 years of underground coal mine employment and a non-smoking history. (LM DX 13). Dr. Schaaf related the miner's complaint that he could not walk uphill or up eight steps without stopping, although he was okay on the level. The miner reported breathing problems when he was still mining. (LM DX 13).

Based on examination, history, a nonqualifying pulmonary function study showing mild airflow obstruction but normal vital capacity and a ("1/2") positive chest X-ray, Dr. Schaaf diagnosed CWP and found his disabling dyspnea due to CWP. (LM DX 13). He added, "In addition, there is no alternative explanation for his breathlessness save to evoke the obvious lung disease that he already has, i.e., coal workers pneumoconiosis." (LM DX 13).

Dr. Schaaf testified at a deposition on November 20, 2000, which was admitted post-hearing. (LM DX 45). He reiterated his credentials and the substance of his earlier report. He testified he actively treats patients with various pulmonary afflictions. Since his report he reviewed additional enumerated materials including portions of Dr. Morgan's deposition. He observed Mr. Ohler had been exposed to both rock dust and coal dust in his mining career. (LM DX 45 at 17). He did not find him obese or overweight, but did not ascertain his ideal weight. (LM DX 45 at 17, 69). In fact, he disagreed with Dr. Morgan's assessment that the miner's weight played any role in his impairment. (LM DX 45 at 42-50, 68). He testified concerning the crackles, sounds associated with interstitial lung disease, such as IPF, he observed on examination of the miner. (LM DX 45 at 19-21, 73). He believes CWP can show both rounded and irregular opacities on X-ray and medical literature reflects the same. (LM DX 45 at 25-28, 76-79, 98). He was not aware of any etiology for the miner's interstitial fibrosis other than coal mine dust exposure. (LM DX 45 at 29). If Mr. Ohler had a five pack-year smoking history it would have little significance. (LM DX 45 at 31-32). He added that the miner's 1999 AGS results are consistent with simple CWP. (LM DX 45 at 33). His 1984 and 1991 AGS showed borderline impairments. (LM DX 45 at 34).

Dr. Schaaf defined IPF and ruled it out here. (LM DX 45 at 36, 86-89). He could not imagine the miner had IPF in 1984 and still be living; rather it must have been CWP. (LM DX 45 at 39-40, 81). He observed there is no requirement that CWP first appear on X-ray in the upper lung zones, but the traditional description is that it tends to be there. (LM DX 45 at 51-52). Simple CWP can progress post-coal dust exposure and cause worsening pulmonary

[22] Dr. Schaaf became a B-reader in 2005.

function. (LM DX 45 at 51-53, 66). One cannot differentiate opacities caused by coal dust versus silicates by X-ray. (LM DX 45 at 54-55). Dr. Schaaf believes the miner's condition had been worsening. (CX 12, pp. 56). It is medically sound for the miner to be utilizing supplemental oxygen and bronchodilators. (LM DX 45 at 57-58). Mr. Ohler has no sarcoidosis. (CX 12, pp. 58-59). Although Mr. Ohler did not retire until 1990, his AGS results (PO2 of 60) showed a severe impairment of lung function. (LM DX 45 at 62). While he may, in the strictest definitional sense, have chronic bronchitis, Dr. Schaaf did not believe it was his disease process. (LM DX 45 at 75).

Dr. Schaaf disagreed with the ATS position that FEV-1 to FVC ratio, which he used to assess the mild obstructive impairment, is not useful in assessing the severity of lung disease, based upon his own clinical experience treating patients. (LM DX 45 at 71). He has also found the "percentage of predicted value of the FEV-1" test is not helpful as the sole test of lung function.(LM DX 45 at 71-73).

Dr. Schaaf issued two additional medical reports after the miner's death, dated May 12, 2005 and August 26, 2005, respectively. (LM CX C1; WM CX 1 LM CX C2). He was again deposed, on August 26, 2005. (LM CX J). Dr. Schaaf reiterated his conclusion that the miner had CWP, basing this opinion on a history of coal mine employment, X-ray evidence, and similar findings of numerous pathologists who concluded likewise. (LM CX C1; WM CX 1 at 6). Dr. Schaaf also reiterated his opinion that, based on blood-gas evidence, the miner had a pulmonary impairment that prevented him from performing his prior coal mine employment at the time of his evaluation. (LM CX J at 16). He further opined that CWP substantially contributed to the miner's death. To that end, he elaborated that the combination of mild pulmonary edema and CWP produced the fatal cardiac arrhythmia. (LM CX C1; WM CX 1 at 6-7). Dr. Schaaf reasoned that because of the miner's significant lung compromise, the mild pulmonary edema developed into the fatal cardiac arrhythmia. (LM CX C1 at 7).

Dr. Waheeb Rizkalla, who is Board-certified in anatomic and clinical pathology, issued a consultative medical report dated February 18, 2004. (LM CX G). Dr. Rizkalla based his report on his review of voluminous medical records and microscopic slides from the miner's autopsy. Dr. Rizkalla was also deposed on November 3, 2005, and the transcript of that deposition is part of the record. (LM CX G). Dr. Rizkalla concluded that the miner had CWP, centrilobular and focal dust emphysema, and focal interstitial fibrosis. (LM CX K; LM CX G at 17). He concluded that all three were caused by coal dust exposure. (LM CX G at 21-23). Dr. Rizkalla also cited evidence of hypoxia, which he attributed to the miner's lung condition and, by extension, his coal dust exposure. (LM CX G at 36; 53).

Dr. Christopher Begley, an A-reader who is Board-certified in internal medicine, pulmonary medicine, and critical care medicine, issued a consultative medical report dated June 1, 2005. (LM CX E; WM CX 2). He was deposed on March 6, 2006 and the deposition transcript is part of the record. (LM CX L). Dr. Begley reviewed medical records, pathology reports, and autopsy findings in preparing his report. (LM CX L at 8). He concluded that the miner suffered from CWP, an opinion he based on the miner's employment and coal-dust exposure history, X-ray evidence, and autopsy evidence. (LM CX E; WM CX 2). He further concluded that CWP was a "substantial contributing factor" to the miner's death. (LM CX E;

WM CX 2). To that end, he stated that the miner exhibited significant arterial hypoxemia, which contributed to myocardial ischemia and eventual death. (LM CX E; WM CX 2; LM CX L at 9-10).[23] The arterial hypoxemia was a consequence of CWP. (LM CX L at 9-10). Dr. Begley repeatedly explained, in painstaking detail, the processes by which CWP gave rise to hypoxemia and how hypoxemia played a key role in the manner in which the miner died. (LM CX L at 35, 58). Dr. Begley further stated that he found no other diagnosis that would have explained the miner's hypoxemia. (LM CX L at 10).

Dr. Joshua A. Perper, who is Board-certified in anatomic, surgical, and forensic pathology, Chief Medical Examiner of Broward County, Florida, and a clinical professor at the University of Miami, submitted reports dated March 23, 2003 (LM DX 101; WM CX 3) and December 29, 2003 (LM CX I; WM CX 4).[24] He was deposed on December 5, 2003 (LM EX 13) and March 6, 2006 (LM CX M).

In preparation for his March 23, 2003 report, Dr. Perper reviewed the autopsy report, autopsy slides, and voluminous medical records. Based upon his review of the autopsy slides, Dr. Perper made the following diagnoses:

(1) CWP, simple, severe, with macules, coal dust type micronodules, macronodules and focal (scar) emphysema;
(2) Chronic centrilobular emphysema, moderate to marked;
(3) Hamartoma (Chondroma), benign, of lung;
(4) Acute and chronic congestion and edema of lungs;
(5) Sclerosis of intra-pulmonary blood vessels consistent with pulmonary hypertension and cor pulmonale;
(6) Arteriosclerosis of native coronary arteries;
(7) Patent coronary grafts;
(8) Fibrino-hemorrhagic organizing pericarditis;
(9) Focal hypertrophy of myocardial fibers;
(10) No evidence of myocardial infarction;
(11) Acute and chronic passive congestion of liver;
(12) Focal depletion of lipids in adrenal cortex.

(LM DX 101 at 22).

Dr. Perper also offered a variety of opinions concerning the miner's lifetime condition and subsequent death. Based on the miner's employment history, examination reports, chest X-ray evidence, and autopsy reports, Dr. Perper diagnosed the miner with severe simple CWP and cor pulmonale, with correspondent marked pulmonary disabling symptomatology and hypoxemia. (LM DX 101; WM CX 3 at 24-26). He diagnosed cor pulmonale based on EKG, echocardiogram, and autopsy evidence. (LM DX 101; WM CX 3 at 27-28). Dr. Perper specifically disagreed with the conclusions that pulmonary thromboemolism and myocardial infarction were the immediate or primary causes of death, as indicated on the death certificate

[23] Additionally, Dr. Begley testified that he based his finding of hypoxemia on the blood-gas study evidence. (LM CX L at 29).

[24] The admission of these reports in the survivor's claim is subject to the redaction of reference to inadmissible evidence.

and autopsy report, respectively. (LM DX 101; WM CX 3 at 28). He did diagnose CWP and associated centrilobular emphysema as a significant contributory cause of death and a hastening factor of death. He based this conclusion on autopsy findings, the miner's occupational history, and the clinical evidence. (LM DX 101; WM CX 3 at 28-29). He reasoned that CWP led to hypoxemia, which precipitated or aggravated a cardiac arrhythmia. Dr. Perper supported the conceptual validity of this argument with substantial reference to medical literature. (LM DX 101; WM CX 3 at 29-37).

In preparation for his December 27, 2003 report, Dr. Perper reviewed additional physicians report evidence. (LM CX I; WM EX 4). Dr. Perper specifically responded to the written criticisms of his initial report offered by Drs. Naeye and Oesterling.[25] He attacked Dr. Naeye's finding of minimal CWP based on a lack of observed birefringent toxic silica crystals on several grounds, including Dr. Naeye's medical equipment, the causal connection drew, and his premise concerning the toxicity and fibrogenicity of silicates. (LM CX I at 3). With respect to Dr. Naeye's diagnosis of bronchitis and bronchiolitis, Dr. Perper countered that the diagnosis was based solely on a speculative attribution of the affects of the miner's smoking history. (LM CX I at 4). With respect to Dr. Naeye's finding of a lack of black pigment to indicate disabling CWP, Dr. Perper attacked the conclusion drawn from the evidence cited. He also attacked Dr. Naeye's failure to cite a cause of the miner's pulmonary fibrosis if he believed it was not coal dust exposure. (LM CX I at 5). Finally, Dr. Perper disagreed with Dr. Naeye's position that CWP always appears first in the upper lobes of the lungs and are more severe in those lobes. (LM CX I at 5).

Dr. Perper also responded to several of Dr. Oesterling's points.[26] First, he criticized Dr. Oesterling's conclusions concerning the presence of CWP because Dr. Oesterling did not report the size of the pneumocotic micronodules. (LM CX I; WM CX 4 at 10). He also criticized Dr. Oesterling's diagnosis of capillaritis, diffuse intrapulmonary hemorrhage, and vasculitis because the miner lacked the corresponding clinical features for these diagnoses. (LM CX I; WM CX 4 at 11-12). He attacked Dr. Oesterling's conclusion concerning hemosiderosis for lack of citing a mechanism causing this condition. (LM CX I; WM CX 4 at 12). He explicitly disagreed with Dr. Oesterling's diagnosis of a myocardial infarction as cause of death, citing the lack of customary symptoms and characteristics. (LM CX I; WM CX 4 at 12-13). Dr. Perper also criticized Dr. Oesterling's failure to consider a broader array of medical evidence.

Therefore, Dr. Perper ultimately concluded that the reports of both Drs. Naeye and Oesterling were deficient in their consideration of CWP as a substantial cause of death and hastening factor of the death of the miner. Accordingly, he reiterated his conclusions expressed in his March 23, 2003 report. (LM CX I; WM CX 4 at 14).

Dr. Gregory Fino, who is Board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader, reviewed the claimant's medical records on behalf of the employer, examined him and submitted his opinions in a report, dated November 9, 1999. (LM

[25] Because Dr. Naeye's report is inadmissible in the survivor's claim, references to this report are redacted in WM CX 4.

[26] Because Dr. Oesterling's report is admitted in the survivor's claim, this portion of Dr. Perper's report is admitted for that claim as well as the living miner's claim.

DX 26). His report notes thirty-nine years of underground coal mine employment and an "insignificant", pack per day one-year smoking history between 1945 and 1946, which played no role in his disability. (LM DX 26; LM DX 55 at p. 40). Dr. Fino reported the X-rays showed severe diffuse pulmonary fibrosis in the middle and lower lung zones ("LZ") not indicative of CWP. He wrote the miner denied shortness of breath while mining. (LM DX 26). However, later at his deposition, he acknowledged the medical reports show it began in the 1980's. (LM DX 55 at 39). Based on examination, history, a normal EKG, a negative X-ray, a nonqualifying PFS showing combined obstructive and restrictive disease, an AGS showing moderately severe hypoxia, Dr. Fino concluded that the claimant did not have pneumoconiosis and diagnosed idiopathic diffuse interstitial pulmonary fibrosis. (LM DX 26). He opined Mr. Ohler did not suffer from an occupationally-acquired pulmonary condition. Dr. Fino found the miner totally disabled due to his diffuse interstitial pulmonary fibrosis. However, he reported, "[T]here is no causal association between coal mine dust inhalation and the development of diffuse idiopathic pulmonary fibrosis."

Dr. Fino submitted a supplemental report, dated December 10, 1999. (LM DX 29). He had reviewed additional, enumerated medical information. Looking at a 1984 DOL examination report, he reported Mr. Ohler had smoked a pack a day for five years. A February 6, 1991 DOL examination reported a non-smoking history. He concluded the additional information did not change his opinion that Mr. Ohler has diffuse interstitial pulmonary fibrosis not due to coal mine dust inhalation. (LM DX 29).

Dr. Fino testified at a deposition, on November 29, 2000. (LM DX 55). He reiterated his credentials and the substance of his earlier reports. He had had the opportunity to review additional medical information since that time. (LM DX 55 at 5). Mr. Ohler does not have sarcoidosis. (LM DX 55 at 68). Dr. Fino testified that simple CWP can progress and worsen post coal dust exposure, but it unusual for it to do so. (LM DX 55 at 82-83). He testified the X-rays he reviewed, 1991-1999, were very abnormal with diffuse irregular fibrosis representing a diffuse interstitial pulmonary fibrosis. (LM DX 55 at 6). Although he appreciated opacities in the upper lung zones, he did not classify it in accordance with the ILO system because he did not feel it was consistent with a pneumoconiosis Mr. Ohler would be at risk of contracting. (LM DX 55 at 45-47). He agreed the miner was totally disabled, but that it was not due to his coal mine dust exposure. (LM DX 55 at 7-8, 37). The miner has no coal mine dust related pulmonary condition, including "legal" CWP, but diffuse interstitial pulmonary fibrosis. (LM DX 55 at 8-9). He primarily has a restrictive defect and some obstruction. The literature, i.e., Alfred Fishman's text, supports the proposition that those with Mr. Ohler's type of pulmonary fibrosis may survive up to twenty years, but the mean survival rate is six to eight years. (LM DX 55 at 16, 80, 84).

Dr. Fino testified the typical CWP opacity is rounded, but one may see "secondary" irregular ones. (LM DX 55 at 18-20). He admitted one can see irregular opacities in CWP along with rounded ones. (LM DX 55 at 48, 51). However, the mere fact a miner has irregular opacities is not "synonymous" with coal dust inhalation as the cause. (LM DX 55 at 19). The Amandus article, referenced in Green's text, concluded the coal miner's studied irregular opacities had been caused by smoking. (LM DX 55 at 20). The "Irregular Opacities" article referenced by Dr. Schaaf, did not conclude that the irregular opacities in the 46 men they studied

were caused by coal dust exposure, but rather could not say. (LM DX 55 at 21-22, 89). The older one is the more likely to have irregular shaped opacities. (LM DX 55 at 89). CWP usually first presents in the upper lung zones. (LM DX 55 at 56). Dr. Fino discussed how he classifies X-rays, under the ILO system. (LM DX 55 at 43-45).

According to Dr. Fino, while coal dust may cause diffuse pulmonary fibrosis, studies have not established that. (LM DX 55 at 22). Dr. Fino testified the Honma article concerning diffuse interstitial fibrosis is of no use in determining whether coal mine dust causes diffuse interstitial fibrosis. (LM DX 55 at 25-16, 65). Dr. Fino does not believe the evidence is sufficient to establish a causal relationship between coal mining and diffuse interstitial fibrosis. (LM DX 55 at 62).

Dr. Fino's experience is in line with Green's text statement that the overall prevalence of CWP in coal miners between 1978 and 1980 was slightly less than 5%. (LM DX 55 at 26). He agrees with Dr. Green's position that simple CWP does not usually progress post-exposure, however a minority progress to complicated CWP. (LM DX 55 at 27-28). Here, Mr. Ohler's pulmonary condition continued to deteriorate from non-disabled in 1991 to disabled in 1999. (LM DX 55 at 27). The FEF 25/75 is not useful to rate pulmonary impairment. (LM DX 55 at 28). The FEV-1/FVC ratio measures the presence or absence of obstruction, but the degree of obstruction is measured by the absolute FEV-1 value. (LM DX 55 at 28-29). Dr. Schaaf's 1999 PFS was the onset of Mr. Ohler's abnormality. (LM DX 55 at 86).

Dr. Fino testified that as individuals age their normal blood oxygen level decreases. (LM DX 55 at 30-34). However, Mr. Ohler's PO2 is below normal. Dr. Fino found the miner overweight, but without effecting his shortness of breath. (LM DX 55 at 34, 41).

Dr. Fino issued a supplemental medical report dated January 30, 2004. (LM EX 8; WM EX 4). He was deposed again on February 11, 2004. (LM EX 12; WM EX 9).[27] In preparation for the 2004 supplemental report, Dr. Fino reviewed the miner's work history and background information, his own deposition testimony from 2000, the death certificate, autopsy report, reports of Drs. Perper, Naeye, Oesterling, and Tomashefski, PFS evidence, blood-gas evidence, and chest X-ray evidence. (LM EX 8; WM EX 4 at 2-6).[28]

Based on the pathologic evidence, Dr. Fino now diagnosed simple CWP. He also stated his belief that death was multi-factorial, specifically cardiac and pulmonary in nature. He further opined that simple CWP was of insufficient quantity and significance to play a role in the miner's death. (LM EX 8; WM EX 4 at 6).

Dr. Fino attributed the miner's condition to idiopathic diffuse pulmonary fibrosis. He found no evidence of acute hypoxemia. In his report, Dr. Fino stated that there is no evidence that hypoxemia played a role in the miner's death. (LM EX 8; WM EX 4). However, in deposition, he stated that while hypoxemia did not precipitate the cardiac event that caused

[27] In the survivor's claim, however, its admission is subject to the redaction of reference to inadmissible evidence.
[28] I note that the number of chest X-ray readings listed by Dr. Fino is substantially smaller that that which is admitted into evidence in the living miner's case.

death, it was sufficient enough to contribute to death because of how it occupied his lung condition, which did not allow him to survive his heart attack. (LM EX 12; WM EX 9 at 24).

In reaching his conclusion, Dr. Fino cited, with great favor, Dr. Tomashefski's report. He found that report to be well explained and correlated with his own review of the clinical information. (LM EX 8; WM EX 4 at 6; LM EX 12; WM EX 9 at 13-14). To that end, both Dr. Fino and Dr. Tomashefski found the level of pneumoconiosis to be too mild to account for any lung abnormality and both doctors found the condition of interstitial pneumonitis or fibrosis. (LM EX 12; WM EX 9 at 14-15).

Dr. Samuel V. Spagnolo is board-certified in internal medicine with a sub-specialty in pulmonary medicine and is extremely well-published. (LM DX 51). He reviewed enumerated records relating to the claimant and submitted a consultation report dated August 19, 2000. (LM DX 50). Dr. Spagnolo noted 38.5 years of coal mine employment and a zero to five year pack per day smoking history. Based on his review, he found Mr. Ohler does not have any chronic restrictive or obstructive disease arising out of coal mine employment. He observed:

> none of the laboratory reports demonstrates evidence of a significant loss of lung function to account for Mr. Ohler's complaints. Minimal airflow obstruction may be seen when there is extensive lung fibrosis sufficient to result in category 2 or 3 chest radiographic changes. In this situation, total lung capacity is markedly reduced. None of these findings is present in Mr. Ohler. Only one highly questionable blood gas value (Dr. Pickerill in May 1999) over a 16 year period raises the possibility of a clinically significant lung abnormality. . .easily explained by Mr. Ohler's excessive weight. . . the described changes on multiple chest radiographs are not representative of pneumoconiosis of any type. The changes suggest early interstitial lung disease but by no means does this indicate these changes are fibrotic in nature.

LM DX 50 at 4). Dr. Spagnolo concluded Mr. Ohler is "not limited" or "totally" disabled and has "highly questionable evidence of clinically significant lung disease. He has no pulmonary or respiratory impairment attributable to pneumoconiosis or related to his prior coal mine employment. (LM DX 50). Even if he had CWP, Dr. Spagnolo's opinion regarding impairment would not change.

Dr. Spagnolo issued a supplemental report after the miner's death, dated November 30, 2003 (LM EX 5; WM EX 8). In preparation for is supplemental report, Dr. Spagnolo reviewed the death certificate, autopsy report, and several pathology reviews. In his supplemental report, Dr. Spagnolo conceded that the miner had CWP but that it did not contribute in any way to his death. (LM EX 5; WM EX 8 at 2). He reasoned that the miner's symptoms, complaints, and conditions were not related to CWP. Specifically, he found that the miner's reduced PaO_2 and DLCO values, while maintaining normal spirometry levels, were indicative of vasculitis, not pneumoconiosis. He noted that this finding is consistent with the X-ray evidence. Therefore, Dr. Spagnolo opined that the miner's death was caused by cardiac disease, primarily, and severe vasculitis that resulted in chronic lung hemorrhage and fibrosis, secondarily. Conversely, he

symptoms and conditions while living, and subsequent death, were not caused by CWP. (LM EX 5; WM EX 8).

Dr. Spagnolo issued an additional supplemental report dated August 20, 2004. (LM DX 22). In preparation for this report, he reviewed additional medical information and hospital records. Dr. Spagnolo concluded, in rather cursory fashion, that nothing in the additional evidence would cause him to alter his previous medical opinions concerning the miner. (LM DX 22).

Dr. Richard Naeye, who is Board-certified in pathology and a professor of pathology at the Pennsylvania State University College of Medicine issued a consultative medical report dated September 9, 2003 (LM EX 1) and a supplemental report dated February 12, 2004. (LM EX 10). In preparing his reports, Dr. Naeye reviewed the miner's employment history, hospital records, medical records, other medical opinions, autopsy findings, and autopsy slides. (LM EX 1). He noted 28.5 years of coal mine employment, ten of which were underground, and a 5-pack-year smoking history. (LM EX 1). Dr. Naeye concluded that lesions were present in the miner's lungs but that these lesions are unrelated to occupational exposures to coal mine dust. (LM EX 1). He further opined that if any lesions of CWP are in fact present, they are too small and too few in number to have caused any measurable abnormalities in lung function, any disability, or have hastened death. (LM EX 1). Instead, Dr. Naeye concluded that the lesions present in the miner's lungs were related to severe chronic bronchitis and bronchiolitis. (LM EX 1). He based this conclusion on the PFS evidence, presumed genetic factors, and interpretation of Dr. Perper's report, which noted few birefringent silica crystals. (LM EX 1). Dr. Naeye offered his supplemental report in response to Dr. Perper's criticisms of his original report. His supplemental report substantially reiterates the main points of his original report. (LM EX 10).

Dr. Everett Oesterling, who is Board-certified in anatomical pathology, clinical pathology, and nuclear medicine issued a report dated October 6, 2003. (LM EX 3; WM EX 2). Dr. Oesterling was deposed on November 9, 2005. (LM EX 15). Dr. Oesterling reviewed an unspecified record and the histological slides in preparing his report.[29] He concluded that: (1) The miner had mild CWP; (2) The miner's dust related disease was insufficient to produce respiratory impairment or disability during his lifetime; (3) The miner's death was due to diffuse intrapulmonary hemorrhage secondary to capillaritis and diffuse systemic vasculitis; and (4) The miner's death was in no way cause by, contributed to, or hastened by any chronic dust related disease. (LM EX 3; WM EX 2). With respect to his conclusion that CWP did not cause lifetime impairment, Dr. Oesterling reasoned that the medical evidence did not show sufficient structural change to justify such a conclusion. (LM EX 15 at 31). Dr. Oesterling further opined that the hemorrhaging into the lung resulted in hemosiderosis, marked by the presence of hemosiderin in the lung. (LM EX 15 at 36-38). Therefore, he concluded that the scarring in the lung was unrelated to coal dust deposit. (LM EX 15 at 38).

Dr. Joseph Tomashefski, who is Board-certified in anatomical and clinical pathology and Director of the Department of Pathology at MetroHealth Medical Center in Cleveland, Ohio,

[29] Dr. Oesterling stated that he reviewed "all which [Employer's counsel] forwarded to me" but does not specify what is included in that record. Throughout his report and deposition, he references X-ray evidence and the report of Dr. Perper.

submitted a consultative report dated January 20, 2004. (LM EX 6; WM EX 3). Dr. Tomashefski was deposed on February 10, 2004. (LM EX 11).

In preparing his report, Dr. Tomashefski reviewed the miner's death certificate, autopsy report, employment history, X-ray evidence, PFS test evidence, and autopsy slides. Based on his review of the medical records and slides, Dr. Tomashefski concluded that the miner had cardiomegaly and biventricular cardiac failure. This was represented in the lungs by edema and hemorrhage. His cause of death was post-operative cardiac arrhythmia. Dr. Tomashefski further diagnosed the miner with interstitial pneumitis and interstitial fibrosis that he classified as non-specific interstitial pneumonia/fibrosis. He further opined that the contribution of these conditions resulted in right ventricular hypertrophy due in part to cor pulmonale. (LM EX 6; WM EX 3 at 4).

With respect to CWP, Dr. Tomashefski stated that the miner had mild CWP but that the lesions of CWP were of low profusion and would not have caused respiratory symptoms or impairment. Therefore, Dr. Tomashefski found the miner's level of pneumoconiosis not to be severe. (LM EX 11 at 52). Thus, the miner's interstitial fibrosis was not caused by coal dust exposure. Accordingly, he concluded that CWP neither caused nor contributed to his death. (LM EX 6; WM EX 3 at 5).

In deposition, Dr. Tomashefski succinctly summarized his findings, noting that he cited three disease processes in the miner's lungs: (1) Nonspecific interstitial pneumonia; (2) Chronic heart failure; and (3) The miner's pulmonary condition that resulted from coal dust exposure. Of the three, he believed the first two, and not the third, were responsible for the miner's impairment. (LM EX 11 at 44).

Dr. Tomashefski also specifically addressed Dr. Perper's conclusions. He agreed with several of Dr. Perper's diagnoses, including simple CWP. However, he reiterated that he diagnosed CWP only to a mild degree. He also highlighted his diagnosis of diffuse interstitial fibrosis as a major point of contention with Dr. Perper. Dr. Tomashefski stated that diffuse interstitial fibrosis is the major pathological lesion in the miner's lung; Dr. Perper did not diagnose this condition. Dr. Tomashefski also disagreed with Dr. Perper's conclusion that the miner's minimal centriacinar emphysema was caused by coal mine dust. He reasoned that the lesions of centriacinar emphysema do not bear a specific spatial relationship to the few coal macules and micronodules that are present. Rather, Dr. Tomashefski opined that the most likely cause of the miner's centriacina emphysema is cigarette smoke. He further concluded that this condition did not cause or contribute to the miner's death. Therefore, Dr. Tomashefski ultimately concluded that he disagreed with Dr. Perper's conclusions that CWP was a cause or contributing factor in the miner's death. (LM EX 6; WM EX 3 at 5-7).

Dr. Harold G. Ashcraft, who is Board-certified in anatomic and clinical pathology, with a specialty in hematology, issued the autopsy protocol, dated August 24, 2002. (LM DX 97; WM DX 9).[30] He was deposed on November 16, 2004. (LM CX P).

[30] A general word about the admissibility of this document is appropriate here. With respect to the living miner's claim, the document is admitted because the Claimant offered it to the District Director when the case proceeded at that level. 20 C.F.R. § 725.421(b)(2000) states that upon referral to the Office of Administrative Law Judges, the

In his report, Dr. Ashcraft referenced the miner's medical history of pulmonary fibrosis, pneumoconiosis with secondary polycythemia, coronary artery disease, carotid artery disease, and gastroesaphagel reflux disease. He also referenced the miner's history of coal mine employment. Dr. Ashcraft conducted a gross external and internal; examination and microscopic review. The autopsy was restricted to the chest and abdomen. He diagnosed the following:

(1) Cardiomegaly;
(2) Status post coronary bypass grafts (two) patent;
(3) Coronary artery disease;
(4) Acute myocardial infarction;
(5) Pulmonary edema;
(6) Pulmonary emphysema;
(7) Simple nodular CWP;
(8) Chronic passive congestion of the liver.

(LM DX 97).

Dr. Ashcraft reviewed unspecified additional medical evidence in preparation for the deposition. (LM CX P at 22). In the deposition, he opined that the major cause of death was acute myocardial infarction caused by failure to recover from cardiac artery bypass graft surgery. (LM CX P at 26). He further stated that CWP was a substantially contributing factor in death. To that end, he rationalized that CWP was a main contributing factor in the development of cor pulmonale, which then interacted with the coronary artery disease. (WM CX P at 27). Dr. Ashcraft further testified that the miner's cardiac condition was terminal. (WM CX P at 35).

Dr. Ashcraft also testified that he believed the miner was afflicted with a debilitating pulmonary disease during his life caused by CWP. (WM CX P at 67). He stated that the pulmonary disease process due to coal dust was sufficient to cause cor pulmonale. (WM CX P at 68).

III. Physicians' Notes and Hospital Records

WM DX 9-11 contain treatment records from Somerset Hospital, Conemaugh Memorial Hospital, and the Medical Associates of Boswell, respectively.

[District Director] shall transmit certain enumerated documents, which shall be placed in the record. These documents include "all evidence submitted to the [District Director] under this part." Because the Claimant "submitted" the autopsy protocol to the District Director, it has been properly transmitted to this office and is now part of the record.

However, the autopsy protocol is not automatically admitted as part of the record in the survivor's claim. In that claim, it was obtained by the District Director, not submitted by either party. 20 C.F.R. § 725.421 (2001) states that evidence "submitted to the District Director under this part *by the claimant and the potentially liable operator*" shall be transmitted and made a part of the record. (Emphasis added). Because neither party proffered the autopsy protocol at the District Director level, it is not automatically admitted at this level, absent its submission by a party. As indicated *infra*, the Claimant in this case has proffered the autopsy protocol, but only for the purposes of autopsy rebuttal. Therefore, its admission shall be strictly controlled by that proffer.

WM DX 9 documents the miner's coronary surgery and July 29-31, 2002 hospitalization. It reflects that he was discharged on July 31, 2002 with a principal diagnosis of atypical chest pain and secondary diagnoses of gastritis, possible reflux disease, pulmonary fibrosis, pulmonary hypertension, and hypoxia. As described above, WM DX 9 also contains Dr. Ashcraft's autopsy protocol.

WM DX 10 includes a series of chest X-rays from August 12-18, 2002. These X-ray readings indicated cardiomegaly, densities consistent with pneumoconiosis, diffuse interstitial lung disease. They also indicated that interstitial pneumonia should be considered and that the findings consistent with pneumoconiosis are atypical. WM DX 10 also includes the records of treatment from August 12-18 that reflect shortness of breath, congestive heart failure, chronic interstitial lung disease, post-bypass symptoms, COPD, CWP, and hypoxemia. WM DX 10 also includes the final report issued after the miner's death noted a primary discharge diagnosis of congestive heart failure and seven secondary diagnoses:

(1) COPD;
(2) Atrial fibrillation;
(3) Cardiac arrest;
(4) Deep venous thrombosis;
(5) Coronary artery disease, status post coronary artery bypass graft;
(6) Coronary artery disease;
(7) Gastroesophageal reflex disease.

WM DX 11 documents the miner's oxygen treatment as well as a history of black lung and resulting symptoms. It also documented a coronary condition, including pulmonary hypertension and chest pain. WM DX 11 includes four chest X-rays, taken from January 5, 1998-July 30, 2002. These X-rays list impressions of COPD with interstitial fibrosis, diffuse interstitial fibrosis, and obstructive pulmonary disease with interstitial fibrosis. WM DX 11 also includes a PFS test dated May 14, 2001, indicating airway obstruction with probable concurrent restrictive process. WM DX 11 also includes a blood-gas study dated July 30, 2002, indicating low PO_2 and PCO_2.

The Employer submitted the treatment records from Dr. William Thompson, dated December 27 1985-August 23, 2002. (LM EX 14). These records indicate a variety of ongoing treatments, including the use of home oxygen. They include a chest X-ray dated January 5, 1998 that showed COPD and fibrosis. A 1999 physical notes hypoxemia and pneumoconiosis. A 2002 physical notes lightheadedness due to hypoxia, secondary to pulmonary fibrosis and secondary to pneumoconiosis. A July 30, 2002 chest X-ray revealed radiographic evidence of COPD with interstitial fibrosis. A chest impression dated August 22, 2002 reported cardiomegaly and pulmonary densities involving the mid and lower lung zones, consistent with simple pneumoconiosis. The report further noted that the findings were somewhat atypical and suggested considering the possibility of interstitial pneumonia. LM EX 14 also includes the terminal discharge report, which is also part of WM DX 10.

IV. Witness Testimony

In the 2000 hearing, Mr. Ohler testified that he still had breathing problems and is unable to do much about his home. (LM DX 63 at 64). However, he no longer had much of a cough except a productive cough in the mornings. (LM DX 63 at 71). Dr. DeBreeze prescribed his breathing medications. (LM DX 63 at 65). He used a "puffer" and wheezes in the mornings. (LM DX 63 at 71).

In the 2005 hearing, Mrs. Ohler testified that her husband's terminal visit to the hospital was precipitated by a breathing problem. (HT at 15). She also testified that he was on oxygen therapy before he entered the hospital for the last time, and during his time at the hospital. (HT at 15). She approximated that he had been on oxygen therapy for 8-10 years before his death. (HT at 19). Mrs. Ohler also testified that she never saw her husband smoke cigarettes in the over fifty years she knew him. (HT at 18).

Terry Lee Ohler, son of Harvey, also testified at the 2005 hearing. He approximated that Mr. Ohler had been on oxygen therapy since 1990. (HT at 32). He also testified that he noticed his father's breathing problems for approximately 5-8 years before he retired. (HT at 33).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

The living miner's claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he had pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he was totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Moreover, "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*,338 F.3d 501, No. 01-4064 (6th Cir. July 31, 2003), *citing Greenwhich Collieries [Ondecko]*, 512 U.S. 267 at 281.

Because the living miner's claim is the claimant's third claim for benefits, and it was filed before January 19, 2001, under the pre-Amendment version of the Regulations, the Claimant must show that there has been a material change of conditions. [31]

[31] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part…[i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions…
> (Emphasis added).

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the most recent prior denial. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3rd Cir. 1995). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change.

The most recent prior living miner's claim was denied because the Claimant failed to establish any of the elements of entitlement. (LM DX 39-19). The Claimant must show the existence of one of these elements in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

Because the parties have stipulated to the existence of pneumoconiosis and that pneumoconiosis arose out of coal mine employment, two elements adjudicated against the Claimant in the most recent prior denial, the Claimant has established a material change in conditions. (HT 8-9). Therefore, the entire record is considered to determine entitlement in the living miner's claim.

B. Existence of Pneumoconiosis

The parties have stipulated, and I find, that the Claimant has established the presence of pneumoconiosis. (HT 8). This stipulation pertains to both the living miner's and survivor's claim. (HT 9).

D. Existence of Total Disability

The Claimant must show his total pulmonary disability was caused by pneumoconiosis. 20 C.F.R. § 718.204(b). Section 718.204(b)(2)(i) through (b)(2)(iv) and (d) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevented him from engaging in his usual coal mine employment and gainful employment requiring comparable abilities and skills; and lay testimony.

In this case, the Claimant has established total disability based on the results of blood-gas studies, pursuant to § 718.204(b)(2)(ii). Four sets of blood-gas tests were conducted between October 15, 1984 and November 4, 1999. With the exception of the pre-exercise test of May 26, 1991, all the blood-gas studies conducted in the 1990's had "qualifying" results. The 1984 blood-gas test, with "non-qualifying" results is too old to be of much use. More weight may be accorded to a recent blood-gas study over one that was conducted earlier. *Schretroma v.*

Director, OWCP, 18 B.L.R. 1-17 (1993). Therefore, I find that the blood-gas test evidence establishes total disability.

This finding is buttressed by the medical opinion evidence in the record. Thirteen physicians have offered opinions in this case. Four physicians, Drs. Malhotra, Morgan, Schaaf, and Fino, explicitly found the miner to be totally disabled. Three physicians, Drs. Bloom, Parcinski, and Spagnolo, explicitly found the miner not to be totally disabled. Six physicians, Drs. Rizkalla, Begley, Perper, Oesterling, Naeye, and Tomashefski, all of whom offered opinions after death and focused their reports on cause of death, did not explicitly state whether they believed the miner was totally disabled during life.

Of the physicians who offered explicit opinions on whether the Claimant was totally disabled during his lifetime, all four who answered affirmatively offered opinions in connection with the current claim. Only one physician who answered negatively offered his opinion in connection with the current claim. Therefore, with the exception of Dr. Spagnolo, the opinions finding total disability are more recent than those finding no total disability. Consequently, the more recent medical opinion evidence supports the finding of total disability.

Accordingly, based on the blood-gas evidence and medical opinion evidence, I find that the Claimant has established total disability as an element of entitlement.

E. Cause of total disability

To establish disability causation, a miner must establish that he is totally disabled due to pneumoconiosis such that that disease is a "substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." 20 C.F.R. § 718.204(c)(1)(2001).[32] Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

> (1) has a material adverse effect on the miner's respiratory or pulmonary condition; or
> (2) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal miner employment.
>
> 20 C.F.R. § 718.204(c)(1)(ii) & (ii).

At the outset, because I have found that the Claimant has established the presence of pneumoconiosis and total disability, medical reports that conclude otherwise carry minimal weight as to disability causation. The Fourth Circuit has mandated as much, stating that in such circumstances:

> An [Administrative Law Judge] who has found (or assumed *arguendo*) that a claimant suffers from pneumoconiosis and has total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the [Administrative Law Judge] can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation

[32] The Amended version of this provision, as is true of all of § 718 save one sentence, applies to claims filed before and after January 19, 2001. 20 C.F.R. § 718.2 (2001).

> does not rest upon her disagreement with the [Administrative Law Judge's] finding as to either or both of the predicates in the causal chain.

Toler, 43 F.3d at 116; *Scott v. Mason Coal Co.*, 289 F.3d 263, 269 (4th Cir. 2002).

Therefore, in this case, the reports of Drs. Bloom (LM DX 38-6), Parcinski (LM DX 39-13), and Morgan (LM DX 32) are accorded minimal weight for concluding that the miner did not have pneumoconiosis. Dr. Fino's first two reports (LM DX 26; LM DX 29) are accorded minimal weight for the same reason.

Dr. Spagnolo's first report (LM DX 50) is accorded minimal weight as he found no pneumoconiosis and no significant loss of lung function, i.e. no total disability. His two subsequent reports (LM EX 5; WM DX 22) are also accorded minimal weight, pursuant to *Toler*, as they both adopt the finding of the first report concerning pulmonary disability. Although Dr. Spagnolo now reported the presence of pneumoconiosis in his November 30, 2003 report, specifically overruling his earlier diagnosis concerning the disease, he did not similarly replace his earlier finding that the miner was not totally disabled. (LM EX 5). Indeed, while Dr. Spagnolo referenced the miner's lifetime symptoms of extertional dyspnea and fatigue in his November 30, 2003 report, he does not address level of disability. Moreover, in his August 20, 2004 report, Dr. Spagnolo continued to cite evidence of no obstructive or restrictive lung impairment. (WM DX 22). Therefore, and because he referenced his initial report in his second report and then referenced his "earlier opinions" in his third report, I find that the two subsequent reports adopt the opinion of the first report concerning disability causation. Because that conclusion is counter to my finding of total disability, I accord Dr. Spagnolo's two supplemental reports minimal weight on this issue as well.

Other medical reports are accorded minimal weight as to the issue of lifetime disability causation because they focus primarily or exclusively on cause of death. These reports include those of Drs. Rizkalla (LM CX G), Begley (LM CX E), Perper (LM DX 101 & WM CX 3), and the second report of Dr. Fino (LM EX 8).

Of the five medical reports not discredited for the aforementioned reasons, I find the reports of Dr. Schaaf (LM DX 13; LM CX C1; LM CX C2) to be deserving of the most credit.

Generally, to be credited, a medical report must be both well-documented and well-reasoned. A "documented" report sets forth the clinical findings, observations, and facts on which the doctor has based the diagnosis. *Fields v. Director, OWCP*, 10 B.L.R. 1-19 (1987). A report is "reasoned" if the documentation supports the doctor's assessment of the miner's health. *Id*. Upon finding a medical report to be unreasoned, an Administrative Law Judge may reject it entirely or accord it diminished weight in crediting its conclusions. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989).

Medical opinions may also be accorded diminished weight, in whole or in part for a variety of specific reasons. A medical opinion may be accorded diminished weight if it is equivocal. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988). Additionally, a report may be accorded less weight if it does not reflect a "complete picture" of the miner's condition. *Stark*

v. Director, *OWCP*, 9 B.L.R. 1-36 (1986). Finally, a report may be accorded diminished weight if it considers relatively less objective medication data. *Church v. E. Associated Coal Corp.*, 20 B.L.R. 1-8 (1996), *aff'd in relevant part on recon.* 21 B.L.R. 1-51 (1997).

In this case, Dr. Naeye's medical opinion is accorded significantly diminished weight because of its equivocal nature. To that end, Dr. Naeye stated that he is "uncertain" whether the miner had coal-related fibrosis. With respect to the miner's disability, Dr. Naeye "presumed" that genetic factors combined with a brief smoking history accounted for bronchitis, which he identified as the most important lesions in the miner's lungs. (LM EX 1). Therefore, because Dr. Naeye failed to offer explicit conclusions on either the presence of pneumoconiosis or disability causation, his report is accorded minimal weight.

The reports of Drs. Oesterling, Tomashefski, and Malhotra are accorded moderately diminished weight because they do not present a complete picture of the miner's condition.

With respect to Dr. Oesterling, this deficiency is evident in his inability to square his diagnoses of vasculitis and capillaritis- the core of his report- with the miner's blood-gas abnormalities. (LM EX 15 at 85). Indeed, Dr. Oesterling conceded the limitation of what his report reflected, stating that he did not consider voluminous medical records in preparing his report, but instead drew his conclusions almost exclusively from slide review. (LM EX 15 at 92). This limitation, though, devalues his report toward the issue of disability causation because it fails to consider an important element of the miner's condition.

Dr. Tomashefski's report suffers from a similar deficiency. His findings concerning the degree of pneumoconiosis is central to his conclusion on disability causation, that CWP was not present at the level necessary to have caused impairment. Accordingly, when quantifying the level of CWP he perceived, Dr. Tomashefski stated that he believed it would only minimally appear radiographically. In deposition, Dr. Tomashefski commented, "If [CWP] were present, it would be seen only as 0/1 or 1/0 at most." (LM EX 11 at 38.).[33] This point, which is central in explaining his overall position concerning the level of pneumoconiosis does not square with the numerous chest X-ray readings in the record that exceed 1/0.[34] Therefore, Dr. Tomashefski's report does not reflect a complete account of the miner condition on a point central to both his own position and the issue of disability causation generally. His report is accorded diminished weight accordingly.

Dr. Malhotra's report is accorded moderately diminished weight for not including pathology evidence. While it is noted that this deficiency is through no fault of Dr. Malhotra, as the miner was not yet deceased at the time of his report, the fact remains that his report does not include pathology evidence is relevant in determining its degree of credibility when compared with those that did.[35]

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[33] He repeated this assertion later in the deposition. (LM EX 15 at 52).

[34] The record contains thirteen readings that report the presence of pneumoconiosis at a profusion greater than 1/0. (Appendix A).

[35] I also note that, given the autopsy prosector's finding that the miner died due to a cardiac event in 2002, Dr. Malhotra's conclusion that he did not have a cardiac problem in 1999 in not persuasive. Because Dr. Schaaf stated that the miner did not develop coronary disease until just before his death (LM CX C1 at 6), it does not significantly detract from Dr. Malhotra's conclusion that the miner was totally disabled due to CWP.

Dr. Schaaf's report is both well-documented and well reasoned and is not subject to the aforementioned deficiencies exhibited in the other reports. His initial report, and corresponding initial conclusion on disability causation, were based on an examination of the miner and objective medical data. (LM DX 45). His May 12, 2005 report reaffirms, *inter alia*, his conclusions on disability causation after considering the extensively developed medical record, including pathology evidence. (LM CX C1 at 7; LM CX J at 30). Therefore, Dr. Schaaf's most recent opinion considers a complete account of the miner's condition.

Because I fully credit Dr. Schaaf's report, and he concluded that the miner's CWP led to a totally disabling lung condition, I find that the Claimant has established the fourth element, that pneumoconiosis contributed to his total disability.

D. Death due to Pneumoconiosis

Subsection 718.205(c) applies to survivors' claims filed on or after January 1, 1982 and provides that death is due to pneumoconiosis if any of the following criteria are met:

(1) Competent medical evidence established that the miner's death was caused by pneumoconiosis; or
(2) Pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or
(3) The presumption of § 718.304 (complicated pneumoconiosis) is applicable.

20 C.F.R. § 718.205.

Pneumoconiosis is a "substantially contributing cause" of the miner's death if the disease hastens death. 20 C.F.R. § 718.205(c)(5). The Board recently ruled that this standard is satisfied in instances where CWP substantially contributes to another affliction, which, in turn, caused death. *Bailey v. Consolidated Coal Corp.*, BRB No. 05-0324 BLA (Sept. 30, 2005)(unpub.). In so holding, the Board, cited, with favor, "the proposition that persons weakened by pneumoconiosis may expire quicker from other diseases." *Id.* at 6. *Cf. Piney Mountain Coal v. Mays*, 176 F.3d 753 (4th Cir. 1999).[36]

I find that the weight of the evidence on the issue of cause of death supports such a conclusion in this case. The evidence establishes that the miner's CWP led to the development of hypoxemia, which hastened death by aggravating the terminal cardiac arrhythmia. Both medical reports submitted in support of the survivor, authored by Dr. Schaaf (WM CX 1) and Dr. Begley (WM CX 2), respectively, report such a process.[37] These reports are well-documented, well-reasoned, and reflective of the evidence in the record in the survivor's claim. Moreover, I find

[36] *But see Eastover Mining Co. v. Director, OWCP [Williams]*, 338 F.3d 501(6th Cir. 2003)(holding that legal pneumoconiosis only hastens death if it does so through a specifically defined process that reduces the miner's life by an estimable time.).
[37] Dr. Begley more fully details this process in his deposition. (WM CX 9 at 50).

that their marked consistency provides reciprocal support for each report, and, thus, for the conclusion overall.[38]

I further find that this evidence remains supportive of the aforementioned process, and corresponding role of CWP in death, after consideration of evidence to the contrary. The reports that discounted the role of CWP in death presented disparate theories as to the miner's condition, which, when compared with the consistency of those that found CWP contributed to death, is cumulatively less persuasive. Specifically, Drs. Spagnolo and Oesterling each cite cardiac disease and vasculitis as the miner's primary condition that led primarily to his death. (WM EX 8; WM EX 2). Drs. Fino and Tomashefski each cite nonspecific interstitial pneumonia/idiopathic diffuse pulmonary fibrosis for the same purposes.[39] While I find the reports of Drs. Spagnolo, Fino, Oesterling, and Tomashefski to be well-documented and well-reasoned for the purposes of the survivor's claim, their divergence in characterizing the miner's condition bears adversely on the persuasiveness of each report individually and on the finding of a diminished role of CWP in death, generally.

Therefore, because of the consistency of physicians' opinion evidence pointing in one direction, compared with the inconsistency of other physicians' opinion evidence pointing in another direction, I find that that consistent evidence shall control. Accordingly, I find that Claimant has established that the CWP led to the development of hypoxemia, which in turn, aggravated the conditions that led to his death in the face of the terminal cardiac arrhythmia. Similar to the process cited in *Bailey*, this process amounts to a hastening of death. Therefore, the Claimant has established that CWP hastened the miner's death.

F. Date of entitlement[40]

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis.[41] 20 C.F.R. § 725.503. Dr. Parcinski found only a mild impairment in 1991, in spite of a "qualifying" AGS result. Dr. Morgan opined the claimant's condition clearly developed between 1996 to 1997 and was progressing. The miner's pre-exercise AGS was thereafter "qualifying" in November 1999. It was at that time Dr. Malhotra found his condition significantly bad. However, he could have reached total disability at any time between 1991 and 1999. Thus, I am unable to ascertain an exact onset date. Therefore, the onset date will be the first day of the month in which he filed his claim. Mr. Ohler filed his claim on March 10, 1999.

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[38] Dr Perper's autopsy report also reports this process, though I accord this conclusion significantly diminished weight as it is largely premised on inadmissible evidence. (WM CX 3 at 28-29).
Specifically, Dr. Perper stated that he based this particular conclusion on autopsy findings, the miner's occupational history, and clinical documentation and laboratory evidence. Because Dr. Perper's report has been designated as an autopsy report and not a medical report, references to information that exceeds his own slide review and the prosector's gross description must be redacted. Because he explicitly states that this conclusion is premised upon this inadmissible evidence, that conclusion is accorded significantly diminished weight.

[39] Dr. Fino testified that the two names refer to the same medical condition. (WM EX 9 at 26).

[40] 20 C..R. § 725.503(g) provides: "Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant."

[41] The date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1310 (1984).

He was therefore entitled to augmented benefits as of March 1, 1999 until July 31, 2002. Mrs. Ohler is entitled to survivor's benefits, beginning August 1, 2002.

ATTORNEY FEES

Thirty days is hereby allowed to the claimant's counsel for the submission of such an application. Counsels'' attention is directed to 20 C.F.R. §§ 725.365- 725.366. A service sheet showing that service has been made upon all the parties, including the claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging of a fee in the absence of an approved application.

CONCLUSIONS

In the living miner's claim, the Claimant has established that a material change in conditions has taken place, because he has now established each element of entitlement. The miner had pneumoconiosis and the disease arose out of his coal mine employment. He was totally disabled due to the disease and that total disability was due to pneumoconiosis. Finally, his death was caused by pneumoconiosis. Therefore, the Claimant is entitled to benefits for both the living miner's and survivor's claim.

ORDER

IT IS HEREBY ORDERED that the claims of MARY LOU OHLER, on behalf of and as surviving spouse of HARVEY OHLER are GRANTED.

IT IS FURTHER ORDERED that the employer, ISLAND CREEK COAL COMPANY shall pay all benefits to which she is entitled under the Act, commencing March 1, 1999.

IT IS FURTHER ORDERED that ISLAND CREEK COAL COMPANY shall reimburse the Black Lung Disability Trust Fund for interim benefits paid to the Claimant.

A

RICHARD A. MORGAN
Administrative Law Judge

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board

before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[42] At the time you file an appeal with the Board, you **must also send a <u>copy</u>** of the appeal letter **to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210**. *See* 20 C.F.R. § 725.481.

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

[42] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **<u>actual receipt</u>** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.

Appendix A

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
LM DX 38-9	10/15/84 10/15/84	Onderka	BCR		0/1, p/s	Compared tp 1/31/83 no essential change in diffuse findings of CWP.
LM DX 38-10	10/15/84 12/16/84	Greene	B; BCR	1	1/1, p/q, 6 LZ	
LM DX 39-16	02/06/91 02/06/91	King	B; BCR	1	0/0	Mild diffuse interstitial fibrosis consistent with mild COPD.
LM DX 46	02/06/91 05/01/00	Wiot	B; BCR	2		No evidence of CWP. Ill-defined densities both bases unrelated to coal dust exposure, but etiology unknown
LM DX 48	02/06/91 06/27/00	Fino	B; BCI(P)	1	0/0	Severe diffuse pulmonary fibrosis middle & lower LZ not representing CWP.
LM DX 49	02/06/91 07/20/00	W.K.C. Morgan	B	1	1/1, t/s, 4 LZ	No evidence of CWP. No definite emphysema. Fibrosing alveolitis or early interstitial fibrosis inconsistent with dust.
LM DX 43	02/06/91 08/20/00	Mathur	B; BCR	1	1/1, p/q, 6 LZ	
LM DX 16	05/26/99 05/27/99	Mital	B; BCR	1	2/1, t/t, 4 LZ	No active pulmonary disease. Dr. Morgan states t/t opacities are not seen in CWP. (DX 32).
LM DX 17	05/26/99 08/20/99	P. Barrett	B; BCR	2	2/1, t/s, 6 LZ	Co; em.
LM DX 26	05/26/99 11/09/99	Fino	B; BCI(P)	1	0/0	Severe pulmonary fibrosis mid & lower LZ not indicative of CWP.
LM DX 28	05/26/99 12/01/99	Wiot	B; BCR	1		em; IPF; not CWP. Not characteristic of asbestosis. (DX 28).

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
LM DX 30	05/26/99 12/08/99	Spitz	B[43]; BCR	1		No evidence of CWP. Compatible with IPF/UIP not from asbestosis. Ih.
LM DX 32	05/26/99 01/26/00	W.K.C. Morgan	B	1	½, 6 LZ	em; hi; recticular nodulation pattern. Consistent with other disease (not dust). Idio PF suggested.
LM DX 43	05/26/99 08/20/00	Mathur	B; BCR	1	½, p/q, 6 LZ	ax
LM DX 31	05/26/99 12/24/99	Meyer	B; BCR	1		Irregular opacity consistent with UIP/Idiopathic PF not CWP.
LM DX 13	07/01/99 07/01/99	Schaaf	BCI(P)	1	½, , p/s, 6 LZ	Consistent with CWP.
LM DX 26	07/01/99 11/09/99	Fino	B; BCI(P)	1	0/0	Severe Pulmonary Fibrosis mid & lower LZ not indicative of CWP.
LM DX 28	07/01/99 12/01/99	Wiot	B; BCR	1		No CWP. Em; IPF. Not characteristic of asbestosis. (DX 28).
LM DX 30	07/01/99 12/08/99	Spitz	B; BCR	2		No evidence of CWP. Compatible with Interstitial PF not from asbestosis.
LM DX 31	07/01/99 12/24/99	Meyer	B; BCR	2		No evidence of CWP. Compatible with IPF/UIP. Ho; hi.
LM DX 32	07/01/99 01/26/00	W.K.C. Morgan	B	3	1/1, t/s, 6 LZ	Em; hi; reticular nodulation pattern. Consistent with other disease (not dust). Idio PF suggested.
LM DX 42	07/01/99 03/25/00	Mathur	B; BCR	2	2/2, q/r, 6 LZ	
LM DX 43	07/01/99 08/15/00	Brandon	B; BCR	2	3/3, u/r, 6 LZ	ax

[43] Dr. Spitz's resume shows his B-reader status ended 4/30/97, yet he indicates on each reading his is a B-reader. (DX 30).

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
LM CX N	7/01/99 8/25/05	Schaaf	B	1	1/2, p/s	
LM DX 26,	11/04/99 11/09/99	Fino	B	1	0/0	Severe Pulmonary Fibrosis mid & lower LZ not indicative of CWP.
LM DX 28	11/04/99 12/01/99	Wiot	B; BCR	1		em; IPF; no CWP
LM DX 30	11/04/99 12/08/99	Spitz	B; BCR	1		No evidence of CWP. Compatible with IPF not from asbestosis. (DX 30).
LM DX 31	11/04/99 12/24/99	Meyer	B; BCR	2		ca; ho; hi; consistent with IPF/UIP not CWP. Can't exclude malignancy.
LM DX 32	11/04/99 01/26/99	W.K.C. Morgan	B	2	1/2, 6 LZ	em; hi; reticular nodulation pattern. Idio PF suggested. Early honeycombing.
LM DX 42	11/04/99 03/25/99	Mathur	B; BCR	1	2/3, q/r, 6 LZ	

Chest X-Ray Evidence Designated for Survivor's Claim

Exh. # Designating Party	Dates: 1. X-ray 2. Read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation or Impression
LM DX 39-16 Employer	2/6/91 2/6/91	King	B; BCR		0/0	Mild diffuse interstitial fibrosis consistent with CWP.
LM DX 26* Employer	11/4/99 11/9/99	Fino	B	1	0/0	Severe pulmonary fibrosis mid & lower LZ not indicative of CWP.
LM DX 38-9 Employer	10/15/84 10/15/84	Onderka	BCR	Not reported	0/1, p/s	Compared to 1/31/83, no essential change in diffuse findings of CWP.
LM DX 28 Employer	7/1/99 12/1/99	Wiot	B; BCR	1		No CWP Em; IPF. Not characteristic of asbestosis.
LM DX 46 Employer	2/6/91 5/1/00	Wiot	B; BCR	2		No evidence of CWP. Ill-defined densities both bases unrelated to coal

						dust exposure, but etiology unknown.
LM DX 38-10 Claimant	10/15/84 12/16/84	Greene	B;BCR	1	1/1, p/q, 6 LZ	
LM CX N Claimant	7/1/99 8/25/05	Schaaf	B	1	1/2, p/s 6 LZ	
LM DX 43	2/6/91 8/20/00	Mathur	B; BCR	1	1/1, p/q, 6 LZ	
LM DX 42	11/4/99	3/25/99	B; BCR	1	1/1, q/r 6 LZ	

*The Employer has also designated LM DX 55 as rehabilitative evidence, in support of LM DX 26.